Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

# Guidance on the Pharmacological Management of Depression in Children and Young People

**(med 8) Mild Depression**
Treat with non-pharmacological / psychological interventions as first line treatment. If unresponsive follow the guidance for moderate-severe depression.

*N.B. severity of depression may be difficult to establish in LD patients*

**(med 8) Moderate-Severe Depression**
Consider drug treatment in children & young people who have
- difficulty engaging with psychological therapy (e.g. LD)
- had a trial of psychological treatment with no response with documentation of outcomes
- had a MDT review
- been considered for alternative / additional psychological therapy

**Best practice guidance is that medication should be offered in combination with psychological therapy. If psychological therapies are declined, pharmacological therapy can be offered and prescribed following the Trust off label / unlicensed guidance.**
Antidepressants should only be initiated following assessment and diagnosis by a Child & Adolescent Psychiatrist or a Level 3 Non-medical Prescriber within their scope of practice. Monitoring of medication can subsequently be done by NMP.
Under no circumstances should primary care be asked to initiate antidepressant treatment in children and adolescents.

**(med 8) Psychotic depression**
If the patient displays signs of psychoses
- Consider the use of adjunct atypical antipsychotic medication – with careful monitoring of side effects.
- consider early use of antidepressant medication
- Be alert to antidepressant monotherapy resistance – consider combination therapies
- Refer to EIP & psychosis pathway

**Baseline Assessment (med 8)**
- Request medical history from GP/School nurse
- Allergies/intolerance to medication & family history
- Other medication prescribed/used including use of herbal medication, particularly St John's Wort
- Pregnancy/breastfeeding – seek advice from medicines information and/or obstetrician; consider referral to perinatal psychiatry service (Tees only); see NICE CG192 - Antenatal and postnatal mental health: clinical management and service guidance
- Substance misuse, sedative effect may be increased with excessive alcohol use
- History of self-harm, suicidal ideation
- Symptoms that might be considered side effects should be monitored for 7 days before initiating medication
- Family history of bipolar disorder
- Consider differential diagnosis and comorbidity e.g. bipolar disorder
- Any concurrent or past psychotropic medication, e.g. ADHD medication, antiepileptics etc.

Physical examination
- Citalopram – ECG, baseline QT interval & review
- Antipsychotic medication – refer to Psychosis pathway

**(Med 4)** Information on medication to be provided verbal and written – Choice & Medication; Medicines for Children

**(med1) First line treatment: Fluoxetine*** (licensed for 8-18 years) but evidence of efficacy is not established.
- Start 10 mg daily, may increase if necessary to 20 mg daily after 1-2 weeks. *May increase up to **40 mg** in severe cases and/or older children with higher body weight following the off label/off license prescribing guidance. However there is little evidence in its effectiveness as antidepressant in doses higher than 20 mg daily. Higher doses may be beneficial for comorbid anxiety disorders and OCD*
- Must consider that Fluoxetine has a long half-life when adjusting dose.
- Ensure regular contact (recommended at least weekly) for the first four weeks to check general progress, mental state (especially suicidal thoughts, behaviour, self-harm and hostility) and for the presence of adverse drug reactions (see CBNF). Contact should ideally be face-to-face, but not necessarily with prescriber. Encourage family to report concerns. Consider limiting prescriptions to 7 days' supply for first 4-6 weeks. Prescriber must review after 4-6 weeks.
- Fluoxetine has effect of enhancing serum levels of other drugs being used concurrently. Consider possible interactions with alcohol
- Informed consent should be obtained and documented
- Consider using ROMS to measure outcomes.
- **Sertraline and Citalopram are second line antidepressants**

**(med 5) Good response**
If patient responds positively to antidepressant treatment, no symptoms and full functioning for at least 8 weeks, they should continue on that treatment for at least 6 months
Consider longer term treatment e.g. up to 2 years for
- Recurrent depression
- Severe depression

**(med 5) Partial response – consider:**
- Check adherence
- MDT review (review effectiveness of psychological therapy)
- Titration and stabilisation on maximum dose

**(med 5) No response**
- Check adherence
- MDT review (review effectiveness of psychological therapy)
- Consider second-line medication – see advice in boxes below re. switching between SSRIs. N.B. long half-life of fluoxetine

**(med 1) Second-line medication: Sertraline***

- If switching from Fluoxetine, consider the long half-life of this drug - reduce the dose and stop for at least 7 days before initiating Sertraline.
- If switching from citalopram, consider the risk of serotonin syndrome, reduce the dose and consider stopping for up to 7 days before initiating sertraline (if no gap in treatment is clinically necessary, start sertraline at lower dose [25 mg daily])
- For age 12 -18 years start at 50 mg once daily, increase as necessary in steps of 50 mg daily at intervals of at least one week. Max dose 200 mg once daily
- For under 12's, there is no guidance in cBNF on dosage - start at lower dose and proceed with great caution
- Ensure regular contact (recommended at least weekly) for the first four weeks to check general progress, mental state (especially suicidal thoughts, behaviour, self-harm and hostility) and for the presence of adverse drug reactions (see CBNF). Contact should ideally be face-to-face, but not necessarily with prescriber. Encourage family to report concerns. Consider limiting prescriptions to 7 days' supply for first 4-6 weeks. Prescriber must review after 4-6 weeks.

**(med 1) Second-line medication: Citalopram***

- If switching from Fluoxetine, consider the long half-life of this drug - reduce the dose and stop for at least 7 days before initiating Citalopram.
- If switching from Sertraline consider the risk of serotonin syndrome - reduce the dose and consider stopping for up to 7 days before initiating citalopram (if no gap in treatment is clinically necessary, start citalopram at lowest possible dose [10 mg daily])
- Baseline ECG prior to initiation (check QT interval).
- For age 12 -18 years start at 10 mg daily, increase if necessary to 20 mg daily after 2-4 weeks. **Max dose 40 mg daily**.
- For under 12's, there is no guidance in cBNF on dosage - start at lower dose and proceed with great caution
- Ensure regular contact (recommended at least weekly) for the first four weeks to check general progress, mental state (especially suicidal thoughts, behaviour, self-harm and hostility) and for the presence of adverse drug reactions (see CBNF). Contact should ideally be face-to-face, but not necessarily with prescriber. Encourage family to report concerns. Consider limiting prescriptions to 7 days' supply for first 4-6 weeks. Prescriber must review after 4-6 weeks.

**(med 5) Good response**
If patient responds positively ie no symptoms and full functioning for at least 8 weeks, continue on treatment for at least 6 months.
Consider longer term treatment e.g. up to 2 years for

- Recurrent depression
- Severe depression

**(med 5) Partial response: consider**

- Check adherence
- MDT review (review effectiveness of psychological therapy)
- Titration and stabilisation on maximum dose

**(med 5) No response**

- Check adherence
- MDT review (review effectiveness of psychological therapy)
- If Citalopram tried, consider sertraline and vice versa

**(med 5) No response to any pharmacological treatment**

- MDT review: review adherence, reassess diagnosis, comorbidities and complicating factors, psychosocial factors, response to psychological therapy
- Consider inpatient assessment

**(med 1) Discontinuation on recovery (all pharmacological treatments)**

- Gradually reduce the dose over 6-12 weeks with the exact dose being titrated against the level of discontinuation/withdrawal symptoms.
- After remission (no symptoms and full functioning for at least 8 weeks) continue medication for at least 6 months (after the 8-week period)

Caution
Paroxetine and venlafaxine should not be used for the treatment of depression in children and young people.
Tricyclic antidepressants and St John's Wort should also not be used in children with depression

See Safe Transfer of Care Guidance when considering appropriate transfer to primary care.

**Liquid preparations can be used in patients who will not/cannot swallow tablets, or need small or finely-tuned doses (e.g. LD patients)*

Ref: NICE (2017). NICE Pathways – Depression. Using antidepressants in children and young people https://pathways.nice.org.uk/pathways/depression/using-antidepressants-in-children-and-young-people.pdf.

Taylor D, Paton C and Kapur S (2015). The Maudsley Prescribing Guidelines in Psychiatry, 12th Edition. Wiley-Blackwell.